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AVITA HEALTH AND REHAB AT REEDS COVE	2114 N 127TH CT EAST WICHITA, KS 67228

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F 000	INITIAL COMMENTS The following citations represent the findings of a complaint investigation #77825 and Partial Extended Health Resurvey.	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility census totaled 66 residents with 3 residents included in the sample. Three residents were reviewed for abuse. Based on observation, interview, and record review, the facility failed to protect resident #3 from abuse and mental anguish. Findings included: - Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnosis: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death). Review of resident #3's profile page revealed the	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14.

Review of resident #3's significant change MDS (minimum data set) dated 6/3/14 revealed the resident had a short-term memory problem but his/her long-term memory was ok. The resident could identify staff names and faces and knew he/she was in a nursing home. The resident had moderately impaired cognitive skills for daily decision making. The resident had an acute mental status change from his/her normal status. The resident had inattention, disorganized thinking, and psychomotor retardation that fluctuated. The resident had trouble falling or staying asleep, or slept too much and felt tired or had little energy 2-6 days of the previous 14 days. The resident had a total mood severity score of 6, indicating mild depression. The resident did not exhibit any behaviors. The resident required total dependence on two or more staff for toileting, personal hygiene, and bed mobility. The resident had an indwelling catheter and was frequently incontinent of bowel.

Review of resident #3's Cognitive Loss/Dementia (a progressive mental disorder characterized by failing memory and confusion) CAA (care area assessment) dated 6/10/14 revealed the resident had a diagnosis of terminal (progressive disease expected to cause death) dementia and the resident was alert and oriented to him/herself only at times. The resident was very lethargic and admitted to hospice services due to expected continued decline. The resident ' s communication was limited and staff often had difficulty understanding the resident due to encephalopathy and dementia.

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Review of resident #3's Urinary Incontinence/Indwelling Foley Catheter CAA dated 6/10/14 revealed the resident was at risk for increased bowel incontinence due to requiring extensive assistance of two staff for toileting. The resident wore incontinent briefs for dignity and was dependent on staff for personal hygiene. The resident had an indwelling Foley catheter and depended on staff for catheter care.

Review of resident #3's significant change MDS dated 7/18/14 revealed the resident had a BIMS (brief interview for mental status) score of 11, indicating moderate impairment. The resident had inattention and disorganized thinking that was present and fluctuated. The resident felt tired or had little energy and had trouble falling or staying asleep, or slept too much for 2-6 days of the previous 14. The resident had a total mood severity score of 3, indicating minimal depression. The resident did not have hallucinations, delusions, or any behaviors. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder.

Review of resident #3's Cognitive Loss/Dementia CAA dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired cognition. The resident usually understood others and was usually understood by others.

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Review of resident #3's Urinary Incontinence/Indwelling Foley Catheter CAA dated 8/1/14 revealed the resident had occasional urinary incontinence and his/her urinary frequency and incontinence had increased with a recent UTI (urinary tract infection) which the resident received antibiotics for. The resident required extensive assistance with toileting and personal hygiene and wore incontinent briefs for dignity.

Review of resident #3's comprehensive care plan initiated on 2/26/14, revealed the resident preferred to sleep in, and required extensive assistance of one staff with morning cares. On 7/18/14 and again on 8/4/14, staff revised the intervention to say the resident preferred to sleep in and required extensive assistance of one staff with morning cares. The resident had a current diagnosis of insomnia and when he/she slept late into the morning, he/she could eat breakfast late and sometimes skipped lunch. In the toileting schedule portion of the care plan, also initiated on 2/26/14, revealed the resident was continent of bowel and bladder and requested staff assistance with toileting. Staff revised the intervention on 2/26/14 to include for staff to assist the resident to the toilet for safety, monitor pericare, and provide assistance when needed. On 7/18/14, staff added an intervention alerting staff the resident was incontinent of bladder and continent of bowel and requested staff assistance for toileting for safety. It also directed staff to provide assistance when needed and alerted staff the resident requested not to have caregivers of the opposite gender for personal cares. On 8/4/14, staff revised the intervention, but did not indicate what portion of the intervention was revised.

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Review of a dietary note for resident #3 dated 7/14/14 revealed the resident sometimes skipped breakfast because he/she liked to sleep in per the nursing staff.

Review of a nurses note dated 7/14/14 revealed resident #3 still had some confusion.

Review of a nurses noted dated 7/15/14 at 2:19 a.m. revealed resident #3 was alert to person, place, and time, and could voice his/her needs. The resident was incontinent of bladder and continent of bowel. The resident required limited assistance of 1 person with ADLs (activities of daily living). The resident rested in his/her bed at that time. The note did not indicate the resident was sleeping.

Review of a nurses note dated 7/15/14 at 6:05 p.m. revealed the resident ' s cognition continued to improve.

Review of a nurses note for resident #3 dated 7/16/14 at 2:24 a.m. revealed the resident was alert and oriented to person, place, and time and could voice his/her needs. The resident had a bed alarm which staff utilized along with every 2 hour checks while the resident was in his/her room. The resident required extensive assistance of one person with ambulation with a front wheeled walker, toileting, and ADLs. The resident rested in his/her bed at that time.

Review of a nurses note dated 7/17/14 at 12:50 a.m. revealed the resident was alert and oriented to person, place, and time and could voice his/her needs. The resident rested in his/her bed at that time.

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Review of a nurses note dated 7/17/14 at 11:51 p.m. revealed resident #3 was alert and oriented with confusion at times and the resident slept at that time.

Review of resident #3 ' s behavior charting for July 2014 revealed the resident had 2 episodes of confusion from 7/17-7/31/14, both on 7/23/14 during the day shift.

Review of a written statement from the former social services staff B dated 7/23/14 revealed several weeks prior, the resident had told him/her that he/she would prefer to receive showers from nursing staff of his/her same gender. The resident did not list anyone specific or complain about a staff member of the opposite gender. The resident was confused at times during the course of the conversation. The social worker let the charge nurse and administrator know of the resident's request to have a staff member of his/her same gender give him/her a shower.

Review of an OT daily progress note dated 7/23/14 revealed the resident stated he/she had a nurse of the opposite gender that worked at night and he/she was uncomfortable with that staff member being in his/her room. The resident hesitated and explained the staff member of the opposite gender would come in and touch him/her while he/she was in bed and facing the wall and would touch his/her buttocks. That nursing staff told the resident he/she was checking to see if his/her incontinence pad was dry, but the resident stated he/she did not think that was correct. The resident described other situations happening and the non-Caucasian nursing staff of the opposite gender (henceforth referred to as the alleged perpetrator- A.P.) would

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call it " therapy " and said it was good for him/her. The resident described the last holiday when most of the staff were gone, and the A.P. had him/her outside in the courtyard and was rough with him/her in the grass. The resident was afraid if he/she told anyone, he/she would be in trouble. The therapy staff then reassured the resident and the resident stated he/she was afraid to go to sleep at night. The resident told the social services staff B he/she did not want a nursing staff member of the opposite gender with him/her in the shower and the social worker told the head nurse the resident had requested nursing staff of the same gender only. The resident stated nothing had happened the previous couple of nights before 7/23/14, but he/she saw the A.P. working out by the nurses station and when the resident got out of his/her restroom, the A.P. was gone. The resident believed the A.P. was scared because the resident's family member had stayed the night that past Sunday (7/20/14) and that is why the A.P. had not returned to his/her room. The resident stated the A.P. came into his/her room on the night his/her family member stayed the night. The resident reported he/she feared the A.P. would retaliate against him/her if he/she said anything.

Review of a notarized witness statement by therapy staff D dated 7/24/14 revealed it contained the same information included in the OT therapy note from the day prior.

Review of a notarized witness statement dated 7/31/14 revealed therapy staff D stated the resident gave administrative staff A a verbal report of abuse on 7/23/14. Staff D then went and discussed the situation with co-worker therapy

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staff C and then both of them went to administrative staff A and staff D verbally reported the conversation and concerns that the resident explained to him/her about inappropriate behavior. Staff D wrote he/she gave administrative staff A a written statement the following day on 7/24/14.

Review of a notarized witness statement dated 7/31/14 from therapy staff C revealed he/she went with therapy staff D to administrative staff A ' s office on 7/23/14 to talk about what the resident had reported to staff D, as written in the OT daily progress note. Per the statement, staff A looked at the schedule and said the person the resident talked about worked all those nights, so he/she could not be the A.P. Staff C said to administrative staff A that the A.P. worked, but had stayed out of the resident ' s room, he/she thought because the resident ' s family member scared him/her off. Per the statement, staff A stated the resident was confused. Staff C and staff D both told staff A the resident had decreased memory but was alert and oriented to person, place, and time, and was not confused. Staff C wrote in the statement the things the resident had reported were higher level of functioning for thinking, as the resident said "I know if (gender) is not bothering me, (gender) is after someone else here."

Review of the resident's notarized statement dated 7/31/14 revealed the resident had been having a rough time while at the facility and almost died because he/she got very sick. The resident ' s statement included there had been something bothering him/her and he/she reported it to a staff member. The statement indicated the resident did not want to cause any problems and

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he/she did not have any proof, but there had been someone abusing him/her. It had not happened for a while, but it had gone on for the last couple of months, since the spring. The statement indicated the abuser was a non-Caucasian of the opposite gender and told the resident he/she was a nurse. The resident ' s family member stayed all night not too long ago and the A.P. tried to come in then, but the resident thought it scared the A.P. away when he/she saw the resident ' s family member. Per the statement, for 3 days after that, the A.P. stayed away. The resident ' s statement indicated the A.P. always had an excuse that he/she was checking on something to be sure the resident did not fall. The resident reported in the statement he/she knew his/her memory was not very good, but he/she knew what had happened to him/her. According to the statement, the A.P. came into the resident ' s room late at night without knocking and said he/she was trying to see if the residents pants were wet and the A.P. would touch his/her bottom. The resident ' s statement indicated he/she did not make it sound as bad as it actually was. The resident ' s statement included the same incident reported to the therapist on 7/23/14. The resident did not know what the A.P. was trying to do, but the resident hit the A.P. on the arms and it made the A.P. mad and he/she finally gave up. Per the statement, the A.P. had come back and tried to do it again, and the resident had fought him/her off. The resident ' s statement said he/she lay there every night scared the A.P. would come back. The A.P. told the resident it would make him/her feel good and it was " healthy " for him/her. The resident ' s statement indicated he/she hated to think what else the A.P. would have done if he/she had not fought him/her off. The resident did not go to bed until after 1:00

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a.m. sometimes lying awake being afraid about it. The resident ' s statement reported nobody should be disturbed in their sleep as much as the resident was. The resident acknowledged his/her memory could be bad sometimes, but the resident knew he/she was not imagining anything or he/she would not lay there and worry about it all night. The resident ' s statement indicated the abuse had gone on for a couple of months and there were a lot of times the A.P. came in and " messed " with him/her. The resident reported in the statement he/she was very scared every time he/she saw the A.P. and had lost a lot of sleep over it.

Review of an OT daily treatment note dated 7/28/14 revealed the resident stated he/she would rather die and go to heaven than put up what the non-Caucasian staff of the opposite gender did to him/her.

Review of an OT daily treatment note dated 7/29/14 revealed the resident ate breakfast at 11:30 a.m. and the resident stated he/she was up until 1:00 a.m. because he/she was afraid to fall asleep in fear the A.P. would come into her/her room.

Review of a social service progress note dated 8/1/14 revealed the social worker met with the resident in his/her room. The resident knew the date, month, year, and day of week.

Review of the staff assignment sheets from 6/29/14-8/2/14 revealed direct care staff E worked in resident #3 ' s house on night shift on 7/4/14, 7/5/14, 7/6/14, 7/8/14, 7/9/14, 7/10/14, 7/11/14, 7/14/14, 7/15/14, 7/17/14, 7/18/14, 7/19/14, 7/20/14, 7/22/14, 7/23/14, 7/24/14,

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7/25/14, 7/28/14, and 7/29/14. On 8/2/14, direct care staff E worked a double shift for 2nd (2 p.m. - 10 p.m.) and 3rd (10 p.m. - 6:00 a.m.) shift in a different house. Per facility report staff E worked on yet another house for 3rd shift on 8/1/14. For the week of 8/3/14-8/9/14, direct care staff E was scheduled to work in a different house than resident #3 lived in, on 8/3/14, and for double shifts (2nd and 3rd) on 8/8/14 and 8/9/14.

Review of the 24 hour nurse report sheets for July 2014 revealed for resident #3:
7/3/14 day shift- The resident did not want any opposite gender aides.
7/7/14 day shift- Staff were to monitor for self-transfers and voiding on the floor.
7/8/14 night shift- The resident was up at 5:00 a.m. and unmade his/her bed without triggering the bed alarm.

Observation on 7/31/14 at 8:50 a.m. revealed to get to the resident's room, staff had to walk from the hall into a foyer area in the corner and then go around another corner to the left. The resident's bed was located behind the door. The resident's room was not visible from the hallway. The resident's bed was also not visible from the foyer or the hallway.

Interview on 7/31/14 at 12:00 p.m. with the resident's family member revealed the resident especially had a problem with nursing staff of the opposite gender. The resident ' s family member reported direct care staff E, the non-Caucasian staff member of the opposite gender, came in and reset the resident's fall alarm if it went off and he/she thought that bothered the resident. Resident #3 ' s family member revealed the resident did have a little bit of memory loss, but it

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had improved a lot and seemed to be the person he/she knew him/her to be. The family member reported the resident told him/her the same information included in the OT daily progress note dated 7/23/14. The family member reported the night the he/she stayed with the resident, staff E came in and may have been a little shocked to see him/her. The family member reported he/she knew the resident did not have as much confidence in going to sleep as he/she did before. At that time, the family member reported the facility had not talked to him/her about the incident all. The family member reported he/she had talked with the licensed nurse F, and talked to social services staff B and they told him/her they did not believe it was likely to have happened. The family member reported there were only 2 staff that worked at night in the resident ' s house and he/she believed they helped cover other houses. The resident had reported to the family member he/she had asked staff E not to come into his/her room and had told other staff that. The family member reported he/she had talked with the resident about it several times and the resident ' s story was always the same regarding the incident reported on 7/23/14. The family member reported he/she did not believe any of the resident ' s concerns were related to staff E ' s race as the resident had always taught them to love all people regardless of their differences.

Interview on 8/5/14 at 3:47 p.m. with the resident's family member revealed the resident had not ever mentioned the non-Caucasian night shift staff of the opposite gender that he/she was afraid of by name, but the family member reported he/she knew it was direct care staff E because staff E worked in the resident's house a

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lot, more than any other staff member fitting that description. The family member confirmed the night he/she stayed, the non-Caucasian nursing staff of the opposite gender that came in was direct care staff E. The family member reported the resident had never been one to make things up. The family member reported he/she visited the resident at least twice a week every week. The family member reported the resident's cognition was very poor when he/she was sick and almost died, but it had improved a lot in the last month or so. The family member reported the resident had not had any confusion in the last 3-4 weeks. The family member reported he/she felt the resident would always be uncomfortable or afraid if direct care staff E continued working there and he/she hoped direct care staff E would not be working in the facility at night for sure. The family member reported he/she just wanted to be sure the resident could go to sleep peacefully at night.

Interview with the resident on 8/5/14 at 4:10 p.m. revealed the non-Caucasian opposite gender staff member that worked at night that touched him/her inappropriately and made him/her scared was the same person that came in the during the night his/her family stayed. The resident reported he/she was certain of it. The resident had reported he/she had fought the staff member off 3 different times when they tried to touch him/her inappropriately. The resident reported there were a few nights during the previous week (7/27/14-8/2/14) the A.P. came very quietly in the night and he/she lay there awake and scared. The A.P. grabbed the resident ' s door and he/she saw the A.P ' s long fingers come around the edge of the door and the A.P. would just look in and smile, tormenting him/her.

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Interview with direct care staff G on 8/5/14 at 9:59 a.m. revealed when the resident readmitted to the facility, the resident had more confusion but at this time the resident was more with it and hardly ever had confusion. Staff G reported he/she had worked in the facility since February and worked the resident's house about once a month. Staff G reported the resident had not had any days of confusion in the last 3 months he/she had worked the house. Staff G reported he/she had not noticed any concerns with the resident's memory.

Interview with on with direct care staff E 8/5/14 at 2:10 p.m. revealed the resident had not had any confusion on that day.

Interview with direct care staff I on 8/5/14 at 4:52 p.m. revealed he/she regularly worked in resident #3 ' s house for the past 7 months. Staff I reported the resident was very independent at first, went home, came to the facility again, got really sick and was confused then, but had since gone off of hospice services. Staff I reported the resident had not had any confusion in the last couple of weeks.

Interview with licensed nursing staff J on 7/31/14 at 5:48 p.m. revealed the resident did not like nursing staff of the opposite gender to work with him/her.

Interview with licensed nursing staff J on 8/5/14 at 2:08 p.m. revealed he/she had worked with the resident since he/she was admitted. Staff J reported the resident came in after a fall at home and then got really sick with a bad UTI. Staff J reported the resident had occasional confusion, but not very often. Staff J reported the resident's

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confusion had gotten much better in the last couple of weeks.

Interview with social services staff B on 7/31/14 at 6:15 p.m. revealed he/she confirmed his/her written statement from 7/23/14. Staff B reported he/she did not question it because there were many residents that did want nursing staff of the opposite gender to provide personal cares. Staff B confirmed he/she did not document the conversation with the resident anywhere, but told the charge nurse.

Interview on 7/31/14 at 12:59 p.m. and 1:56 p.m. with therapy staff D revealed the resident had some problems with his/her memory, but was not confused. Staff D reported the resident was very fearful to tell him/her about the abuse and reported he/she gave his/her written statement to administrative staff A the day following the resident ' s allegation. Staff D reported he/she gave administrative staff A a statement with a description of the occurrence for the resident, and later that day asked the administrator if he/she had talked to the resident. Staff D reported staff A told him/her that he/she had talked to the resident. Staff D reported he/she had not heard from staff A since that time.

Interview with therapy staff C on 7/31/14 at 2:19 p.m. revealed he/she was with therapy staff D on 7/23/14 when staff D told administrative staff A what the resident said and included the sexual nature of the allegation. Staff D said since the allegation was reported to administrative staff A, the resident had reported to him/her that the A.P. had tormented him/her by coming to the door and looking around and then leaving.

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During an interview with administrative staff A on 7/31/14 at 12:20 p.m. revealed the facility did not have any allegations of abuse that were not called in because he/she always called them in.

Interview with administrative staff A on 7/31/14 at 1:27 p.m. revealed he/she thought the therapist had a concern with the resident and a staff member on 7/23/14 or 7/24/14. Staff A reported he/she went to interview the resident that evening the resident did not identify who was causing his/her problems. The resident talked about things that made him/her sound confused. Staff A reported he/she liked the staff of the same gender and was not afraid to stay in the facility. Staff A confirmed the therapist's concern as he/she had documented in the OT daily progress note. Staff A reported all of the night shift nursing staff of the opposite gender were non-Caucasian. Staff A reported the non-Caucasian direct care staff of the opposite gender had the possibility to work in any house depending on call-ins. Staff A reported if there were a call in, the direct care staff were moved around to help cover all of the houses. Staff A reported direct care staff E worked primarily in two of the four houses, but if there was a call-in, staff E might work anywhere.

On 7/31/14 at 2:56 p.m., interview with administrative staff A revealed when the therapy staff told him/her about the allegation of abuse, he/she talked to the social worker and the staff members that worked in the resident ' s house. Staff A reported he/she asked the staff if the resident had complained about not liking a specific staff member, any complaints about staff in general, or anyone that he/she did not want going in his/her room. Staff A reported he/she spoke with licensed nursing staff L who told

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him/her the resident did not like opposite gender in his/her room since he/she had come back from the hospital but had not mentioned anyone specific. Staff A reported he/she did not obtain written statements or document any of his/her investigation, but reported the social services staff B had provided a written statement. Observation at that time, revealed an unsigned typed statement. Staff A reported he/she did not follow up with the therapist about the concern, but reported to the therapist the next day that he/she was taking care of it. Staff A reported the resident had periods of confusion. Staff A reported the resident had some times where he/she was lucid and times when the resident had odd statements mixed in with the lucid talk. Staff A reported whenever he/she received an allegation of abuse, neglect, or exploitation (ANE), if there was a clear A.P., he/she immediately suspended the A.P. Staff A reported the therapist told him/her the resident would be very willing to tell him/her about it. Staff A reported the allegation would have been considered ANE if the resident were able to corroborate the story the therapist told. Staff A reported he/she did not typically investigate an allegation and then report, but he/she did try to gather as much information as possible before calling something in to report it and because the resident would not or could not report anything to him/her about the allegation, it was not reported. Staff A reported that rolling around in the grass and calling it therapy, did not sound plausible given some of the statements the resident talked about. Staff A reported if he/she truly thought someone had done something to a resident, he/she would have taken action and would have done everything possible to protect the resident. Staff A reported he/she did not interview residents related to the allegation, but had interviewed

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several related to another investigation and none of those interviewed had concerns. Staff A reported during the time of the investigation, he/she had not suspended anyone because he/she did not have an A.P. to suspend because the resident could not pin it down to gender or even race.

Interview with administrative staff A on 8/5/14 at 4:24 p.m. revealed the therapist reported the A.P. was a non-Caucasian nursing staff member of the opposite gender. Staff A reported since the resident could not provide a description of the A.P., he/she decided to suspend all non-Caucasian nursing staff of the opposite gender. Staff A reported there were maybe 3 non-Caucasian nursing staff members of the opposite gender that worked nights routinely. Staff A reported the staff completed resident interviews of every alert and oriented resident in the building and specifically asked if any non-Caucasian staff of the opposite gender had touched them inappropriately. Staff A reported the staff interviewed all non-Caucasian staff of the opposite gender and were unable to identify any evidence to keep the non-Caucasian staff of the opposite gender suspended. Staff A reported he/she visited with the resident ' s family member and reported he/she did not believe it to have happened and reported to him/her that all the night shift non-Caucasian staff of the opposite gender were great people. Staff A reported the resident reported the incident about rolling around in the grass happened during the day, which just was not feasible. Staff A reported the resident had a bed sensor, and if staff were providing cares, the alarm would be going off. Staff A did not know whether staff disabled the alarm while providing cares. Staff A reported the night shift charge

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nurses of the same gender were providing all the personal cares to the resident. Staff A reported the resident had not had any personal cares provided by a staff member of the opposite gender since 7/3/14 that staff knew of. Staff A reported as an addendum to the correction plan would be that there would be no staff of certain gender working in resident #3 ' s house.

Interview with consultant staff K on 8/5/14 at 4:48 p.m. revealed the facility had reviewed the surveillance videos of July 4th and did not see staff in the courtyard with the resident. Staff K reported the facility had reviewed the resident ' s bed alarm log, and could not find a pattern of the resident being more restless at night and the resident had a long standing history of insomnia. Staff K reported all direct care staff were expected to go in and provide fluids for the resident and take out the trash. Staff K reported the resident had a bed alarm to alert staff he/she was getting up on his/her own because the resident lacked safety awareness. Staff K reported the resident was starting to become more independent, but had required incontinence care during that time he/she was very sick until about 7/15/14. Staff K reported the resident did have the bed sensor in place during the time he/she required incontinence care.

Review of the undated facility policy for Abuse, Neglect and Exploitation, revealed all facility employees were educated that all alleged or suspected violations should be reported to the administrator IMMEDIATELY and the administrator or CEO (Chief Executive Officer) would ensure all alleged or suspected violations involving mistreatment, neglect or abuse were investigated and reported immediately to the

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F 223	Continued From page 19 KDADS (Kansas Department of Aging and Disability Services) Complaint hotline within 24 hours of the incident. If there was enough evidence to suspect that an individual may have abused or neglected an elder, that individual would not be allowed to work in the facility or allowed access to the facility until the outcome of the investigation was known. The facility failed to protect resident #3 from abuse and mental anguish after an allegation of abuse on 7/23/14 was reported to administrative staff A.	F 223		
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 20 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility census totaled 66 residents with 3 residents included in the sample reviewed for abuse. Based on observation, interview, and record review, the facility failed to immediately report an allegation of employee to resident sexual abuse and/or inappropriate touching involving 1 sampled resident #3 to the State survey and certification agency, failed to thoroughly investigate the allegation, failed to submit the results of the investigation to the State survey and certification agency within 5 working days, and failed to protect all residents from potential abuse during the investigation. Resident #3 made allegations of inappropriate touching by a non-Caucasian staff member of the opposite gender, who had the potential to work in all four houses of the facility. Resident #3 reported that he/she was afraid to go to sleep at night. This allegation was reported to Administrative staff immediately. Administrative staff failed to report, investigate, and protect other residents after learning of the allegation. This deficient practice	F 225		

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placed all residents in the facility in immediate jeopardy.

Findings included:

- Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnosis: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death).

Review of resident #3's significant change MDS dated 7/18/14 revealed the resident had a BIMS (brief interview for mental status) score of 11, indicating moderate cognitive impairment. The resident had inattention and disorganized thinking that was present and fluctuated. The resident felt tired or had little energy and had trouble falling or staying asleep, or slept too much for 2-6 days of the previous 14. The resident had a total mood severity score of 3, indicating minimal depression. The resident did not have hallucinations, delusions, or any behaviors. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder.

Review of resident #3's comprehensive care plan initiated on 2/26/14, revealed the resident was continent of bowel and bladder and requested staff assistance with toileting. On 7/18/14, staff added an intervention alerting staff the resident

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requested not to have caregivers of the opposite gender for personal cares. On 8/4/14, staff revised the intervention, but did not indicate what portion of the intervention was revised.

Review of resident #3's OT (occupational therapy) daily progress note dated 7/23/14 revealed the resident stated he/she had a nurse of the opposite gender that worked at night and he/she was uncomfortable with that staff member being in his/her room. The resident hesitated and explained the staff member of the opposite gender would come in and touch him/her while he/she was in bed and facing the wall and would touch his/her buttocks. That nursing staff told the resident he/she was checking to see if his/her incontinence pad was dry, but the resident stated he/she did not think that was correct. The resident described other situations happening and the non-Caucasian nursing staff of the opposite gender (henceforth referred to as the alleged perpetrator, A.P.) would call it " therapy " and said it was good for him/her. The resident described the last holiday when most of the staff were gone, and the A.P. had him/her outside in the courtyard and was rough with him/her in the grass. The resident was afraid if he/she told anyone, he/she would be in trouble. The therapy staff then reassured the resident and the resident stated he/she was afraid to go to sleep at night. The resident told social services staff B he/she did not want a nursing staff member of the opposite gender with him/her in the shower and the social worker told the head nurse the resident requested nursing staff of the same gender only. The resident stated nothing happened the past few nights, but he/she saw the A.P. working out by the nurses station and when the resident got out of the restroom, the A.P. was gone. The

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resident believed the A.P. was scared because the resident's family member stayed the past Sunday night and that was why the A.P. had not returned to his/her room. The resident stated the A.P. came into his/her room on the night his/her family member stayed the night. The resident reported he/she feared the A.P. would retaliate against him/her if he/she said anything.

Review of a notarized witness statement by therapy staff D dated 7/24/14 revealed resident #3 reported to staff there was a non-Caucasian nursing staff of the opposite gender that made him/her uncomfortable and touched him/her inappropriately on several occasions. The resident reported to staff D he/she told the social worker that he/she did not want nursing staff of the opposite gender in his/her room and the resident did not tell the social worker why at that time. The resident had seen the A.P. working since then and stated that nothing had happened the couple of nights prior to 7/23/14. The resident explained he/she was afraid of falling asleep at night in fear the A.P. would be coming in.

Review of a notarized witness statement dated 7/31/14 revealed therapy staff D stated the resident gave administrative staff A a verbal report of resident #3's allegations of inappropriate touching and fear of the A. P. on 7/23/14. Staff D then went and discussed the situation with co-worker therapy staff C and then both of them went to administrative staff A and staff D verbally reported the conversation and concerns that the resident explained to him/her about inappropriate behavior. Staff D wrote he/she gave administrative staff A a written statement the following day on 7/24/14.

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Review of a notarized witness statement dated 7/31/14 from therapy staff C revealed he/she went with therapy staff D to administrative staff A's office on 7/23/14 to talk about what resident #3 reported as documented in OT daily progress note on 7/23/14. The resident told staff C his/her family member stayed the night on a Sunday night (July 20th) and that same staff member, the A.P., came into his/her room with his/her family member there. The resident told the A.P. he/she was not to be in his/her room and to get out. The resident said "I know if (gender) is not bothering me, (gender) is after someone else here."

Review of the staff assignment sheets from 6/29/14-8/2/14 revealed direct care staff E, of the opposite gender, worked in resident #3's house on night shift on 7/4/14, 7/5/14, 7/6/14, 7/8/14, 7/9/14, 7/10/14, 7/11/14, 7/14/14, 7/15/14, 7/17/14, 7/18/14, 7/19/14, 7/20/14, 7/22/14, 7/23/14, 7/24/14, 7/25/14, 7/28/14, and 7/29/14. On 8/2/14, direct care staff E worked a double shift for 2nd (2 p.m. - 10 p.m.) and 3rd (10 p.m. - 6:00 a.m.) shift in a different house. Per facility report staff E worked on yet another house for 3rd shift on 8/1/14. For the week of 8/3/14-8/9/14, direct care staff E was scheduled to work in a different house than resident #3 lived in, on 8/3/14, and for double shifts (2nd and 3rd) on 8/8/14 and 8/9/14.

Review of the August 2014 schedule, direct care staff E's assignment changed from resident #3's house to two separate houses for 2nd shift and 3rd shift.

Interview on 7/31/14 at 12:00 p.m. with the resident's family member revealed the resident especially had a problem with nursing staff of the

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opposite gender. The resident ' s family member reported direct care staff E, the non-Caucasian staff member of the opposite gender (now referred to as the alleged perpetrator/A.P.), came in and reset the resident's fall alarm if it went off and he/she thought that bothered the resident. Resident #3 ' s family member revealed the resident did have a little bit of memory loss, but it had improved a lot recently and seemed to be the person he/she knew him/her to be. The family member reported the resident told him/her that on a weekend direct care staff E took the resident outside when there was no one around and rolled him/her on the ground. The resident reported the night the he/she stayed the night with the resident, staff E came in and may have been a little shocked to see him/her. The family member reported he/she knew the resident did not have as much confidence in going to sleep as he/she did before. At that time, the family member reported the facility had not talked to him/her about the incident all. The family member reported he/she had talked with licensed nurse F, and to social services staff B about the allegations of inappropriate touching by a staff member of the opposite gender and they told him/her they did not believe it was likely to have happened. The family member reported he/she had talked with the resident about it several times and the resident ' s story was always the same.

During an interview with administrative staff A on 7/31/14 at 12:20 p.m. revealed the facility did not have any allegations of abuse that were not reported to the State complaint hotline because they always called them in.

Interview on 7/31/14 at 12:59 p.m. with therapy staff D revealed resident #3 had some problems

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with his/her memory, but was not confused. Staff D reported the resident was very fearful to tell him/her about the abuse and reported he/she gave his/her written statement to administrative staff A the day following the resident ' s allegation.

Interview with administrative staff A on 7/31/14 at 1:27 p.m. revealed he/she thought the therapist had a concern with the resident and a staff member on 7/23/14 or 7/24/14. Staff A reported he/she went to interview the resident that evening, and he/she was very confused. Staff A reported he/she liked the staff of the same gender and was not afraid to stay in the facility. Staff A reported the therapist's concern was that there was an opposite gender staff member that came and took the resident out into the courtyard and rolled him/her around in the grass and something else the therapist was concerned with. Staff A reported all of the night shift nursing staff of the opposite gender were non-Caucasian. Staff A reported the non-Caucasian direct care staff of the opposite gender had the possibility to work in any house depending on call-ins and staff A reported direct care staff E worked primarily in two houses, but if there was a call-in, staff E could work anywhere.

Interview with therapy staff C on 7/31/14 at 2:19 p.m. revealed he/she was with therapy staff D on 7/23/14 when staff D told administrative staff A what the resident said and it did include the sexual nature of the allegation. Staff D since the allegation was reported to administrative staff A, the resident reported to him/her the A.P. tormented him/her by coming to the door, looking around and then leaving.

On 7/31/14 at 2:56 p.m., interview with

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administrative staff A revealed he/she did not obtain written statements or document any of his/her investigation, but reported social services staff B had provided a written statement. Observation at that time, revealed an unsigned typed statement. Staff A reported he/she did not follow up with the therapist about the concern. Staff A reported the next day after the therapist told him/her about the allegation, the therapist came in and asked him/her what staff A had done about it and then provided a written statement. Staff A reported the resident had periods of confusion. Staff A reported whenever he/she received an allegation of abuse, neglect, or exploitation (ANE), if there was a clear A.P., he/she immediately suspended the A.P. Staff A reported the therapist told him/her the resident would be very willing to tell him/her about it. Staff A reported the allegation would have been considered ANE if the resident were able to corroborate the story the therapist told. Staff A reported he/she did not typically investigate an allegation and then report it to the State agency, but he/she did try to gather as much information as possible before calling something in to report it and because the resident would not or could not report anything to him/her about the allegation, so it was not reported. Staff A reported that rolling around in the grass and calling it therapy, did not sound plausible given some of the statements the resident talked about. Staff A reported if he/she truly thought someone had done something to a resident, he/she would take action and would do everything possible to protect the resident. Staff A reported he/she did not interview residents related to the allegation, but had interviewed several related to another investigation and none of those interviewed had concerns. Staff A reported during the time of the investigation,

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he/she had not suspended anyone because he/she did not have an A.P. to suspend because the resident could not pin it down to gender or even race.

Interview with administrative staff A on 8/5/14 at 4:24 p.m. revealed the therapist reported the A.P. was a non-Caucasian nursing staff member of the opposite gender. Staff A reported since he/she could not provide a description of the A.P., he/she decided to suspend all non-Caucasian nursing staff of the opposite gender on 7/31/14, 8 days after therapy staff reported the allegation to him/her. Staff A reported there were maybe 3 non-Caucasian nursing staff members of the opposite gender that worked nights routinely. Staff A reported the staff completed resident interviews of every alert and oriented resident in the building and specifically asked if any non-Caucasian staff of the opposite gender had touched them inappropriately. Staff A reported the staff interviewed all non-Caucasian staff of the opposite gender and were unable to identify any evidence to keep the non-Caucasian staff of the opposite gender suspended. Staff A reported the resident reported the incident about rolling around in the grass happened during the day, which just was not feasible. Staff A reported the facility had originally suspended the 4 non-Caucasian staff of the opposite gender at the time the surveyor notified him/her of the immediate jeopardy on 7/31/14. Upon further questioning, he/she decided to suspend the 4 non-Caucasian staff for the night shift for 7/31/14. Staff A reported as part of the facility's plan of correction for the immediate jeopardy, every single employee participated in the in-services about abuse, neglect, and exploitation. Staff A reported he/she interviewed the suspended non-Caucasian

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nursing staff of the opposite gender and each of them had very consistent stories and knew the resident preferred nursing staff of the same gender and had not wanted opposite gender caregivers since 7/3/14. Staff A reported the resident had not had any personal cares provided by a staff member of the opposite gender since 7/3/14 that staff knew of. Staff A reported as an addendum to the correction plan would be that there would be no staff of certain gender working in the Saghbene house.

Interview with consultant staff K on 8/5/14 at 4:48 p.m. revealed the facility had reviewed the surveillance videos of July 4th after they were notified of an immediate jeopardy situation and did not see staff in the courtyard with the resident. Staff K reported the facility reviewed the resident's bed alarm log, and could not find a pattern of the resident being more restless at night and the resident had a long standing history of insomnia. Staff K reported all direct care staff were expected to go in and provide fluids for the resident and take out the trash. Staff K reported the resident had a bed alarm to alert staff he/she was getting up on his/her own because the resident lacked safety awareness. Staff K reported the resident was starting to become more independent, but had required incontinence care during the time he/she was very sick until about 7/15/14. Staff K reported the resident did have the bed sensor in place during the time he/she required incontinence care. Staff K reported when the facility completed the investigation regarding to allegation of abuse and could not substantiate the investigation. Staff K reported the facility had re-arranged the staff assignments so there were not any staff of the opposite gender working in the resident's house.

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F 225	Continued From page 30 Interview with administrative nursing staff A on 8/6/14 at 8:27 a.m. revealed the facility would report any allegations of ANE to the State and investigate them. Staff A reported to investigate, staff interviewed the resident if the resident was able to talk, interviewed the staff that worked directly with the resident close to the time frame of the injury or ANE allegedly occurred. Staff A reported staff assessed the resident and notified the physician. Staff A reported he/she tried to interview at least 3 alert and oriented residents about a situation close to what the allegation was. Staff A reported if there was an identified A.P., the individual was suspended immediately. Staff A reported the residents and families were informed on admission they could feel free to voice their concerns during the admission process and reminded during resident council of the Ombudsman (resident advocate program) number and complaint hotline. Staff A reported the residents were also told they could voice their concerns without fear of reprisal. For reporting, staff A reported the facility called in any allegations of ANE to the complaint hotline within 24 hours at the latest or as soon as the allegation was made and if there was reasonable suspicion of a crime, the facility contacted the police immediately. Staff A reported for corrective actions, it depended on the nature of the allegation. Staff A reported the facility conducted immediate corrective actions, then brought the issue to the Quality Assurance committee. Staff A reported they looked at the need for staff education, in-services, and trained all the staff if a need was identified. Observation during the interview, revealed staff A read from the facility policy to answer the questions.	F 225		

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Interview on 8/6/14 at 8:33 a.m. revealed administrative staff A reported he/she could not explain why he/she did not call in the allegation of abuse against resident #3 to the complaint hotline. Staff A reported there was a lot going on in the facility that week. Staff A reported if he/she felt like the allegation would be substantiated, then he/she would have called it in. Staff A reported when he/she completed his/her preliminary investigation, it did not come together and he/she did not have a definite A.P. to suspend.

Review of the undated facility policy for Abuse, Neglect and Exploitation, revealed all facility employees were educated that all alleged or suspected violations should be reported to the administrator IMMEDIATELY and the administrator or CEO (chief executive officer) would ensure all alleged or suspected violations involving mistreatment, neglect or abuse were investigated and reported immediately to the KDADS (Kansas Department of Aging and Disability Services) Complaint hotline within 24 hours of the incident. If there is enough evidence to suspect that an individual may have abused or neglected an elder, that individual will not be allowed to work in the facility or allowed access to the facility until the outcome of the investigation was known.

The facility failed to complete a thorough investigation of abuse and exploitation after an allegation of employee to resident sexual abuse and/or inappropriate touching involving resident #3 to the State survey and certification agency, failed to thoroughly investigate the allegation, failed to protect all the residents during the investigation.

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F 225	Continued From page 32 The facility abated the immediate jeopardy on 8/5/14 at 5:00 p.m. when the facility completed their investigation, provided re-education on ANE to all employees on reporting allegations, suspended all non-Caucasian staff of the opposite gender that were in the building the time the immediate jeopardy was identified, then all non-Caucasian staff of the opposite gender until the facility ' s investigation was complete. The alleged perpetrator was also removed from the facility and was not expected to return. This deficient practice of failure to report, thoroughly investigate and report an allegation of abuse, exploitation, and protect residents during the investigation, remained at a scope and severity of an F.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 66 residents, with 3 residents selected for sample. Based on observation, interview and record review, the facility failed to honor resident #3's preference to not have care givers of the opposite gender.	F 242		

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Findings included:

- Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnoses: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death).

Review of resident #3's profile page revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14.

Review of resident #3's significant change MDS (minimum data set) dated 7/18/14 revealed the resident had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder.

Review of resident #3's Cognitive Loss/Dementia CAA (care area assessment) dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired cognition. The resident usually understood others and was usually understood by others.

Review of resident #3's temporary care plan dated 4/18/14 revealed staff developed a temporary care plan for resident #3 upon his/her

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readmission to the facility. According to that care plan, resident #3 preferred only care givers of the same gender. On 7/18/14, staff added an intervention to the resident's comprehensive care plan alerting staff the resident was incontinent of bladder and continent of bowel and requested staff assistance for toileting for safety. It also directed staff to monitor pericare and provide assistance when needed and alerted staff the resident requested not to have caregivers of the opposite gender for personal cares.

Review of resident #3's nurses note dated 5/8/14 revealed the resident was alert with some confusion and able to make his/her needs known.

Review of resident #3's progress notes from 6/2/14- 8/5/14 revealed no mention of the resident not wanting nursing staff of the opposite gender to work with him/her.

Review of a nurses note for resident #3 dated 7/16/14 at 2:24 a.m. revealed the resident was alert and oriented to person, place, and time and could voice his/her needs. The resident had a bed alarm (device used to alert staff the resident attempted to get up) which staff utilized along with every 2 hour checks while the resident was in his/her room. The resident required extensive assistance of one person with ambulation with a front wheeled walker, toileting, and ADLs (activities of daily living).

Review of a written statement from the former social services staff B dated 7/23/14 revealed several weeks prior, resident #3 had told him/her that he/she would prefer to receive showers from nursing staff of his/her same gender. The resident was confused at times during the course

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of the conversation. The social worker let the charge nurse and administrator know of the resident's request to have a staff member of his/her same gender give him/her a shower.

Review of an OT (occupational therapy) daily progress note dated 7/23/14 revealed the resident stated he/she had a night shift nurse of the opposite gender which made him/her uncomfortable and did not want that staff member in his/her room. The resident told the social services staff B he/she did not want a nursing staff member of the opposite gender with him/her in the shower and the social worker told the head nurse the resident had requested nursing staff of the same gender only.

Review of the 24 hour nurse report sheets for July 2014 revealed for resident #3:
7/3/14 day shift- The resident did not want any aides of the opposite gender.

Review of the staff assignment sheets from 6/29/14-8/2/14 revealed the facility staffed a direct care staff of the opposite gender 31 night shifts out of 35 and 5 shifts out of 35 for day shift in resident #3's house. The facility staffed an opposite gender nurse 4 shifts out of 70 shifts in resident #3's house.

Review of a notarized witness statement by therapy staff D dated 7/24/14 revealed resident #3 had reported to staff that he/she did not want nursing staff of the opposite gender in his/her room. The resident reported to staff D he/she told the social worker that he/she did not want nursing staff of the opposite gender in his/her room and the resident did not tell the social worker why at that time.

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Review of an OT daily treatment note dated 7/28/14 revealed resident #3 stated the direct care staff of the opposite gender had been in to fix the bed alarm

Interview on 7/31/14 at 12:00 p.m. with resident #3's family member revealed the resident especially had a problem with nursing staff of the opposite gender. The resident had reported to the family member he/she had asked staff E not to come into his/her room and had told other staff that.

Interview on 8/5/14 at 3:47 p.m. with resident #3's family member revealed the night he/she stayed the night, direct care staff E came in during the night.

Interview with direct care staff M (of the opposite gender) on 7/31/14 at 9:03 a.m. revealed he/she had only helped resident #3 once or twice. Staff M reported the resident required to have his/her incontinence product changed in the morning.

Interview with licensed nursing staff J on 7/31/14 at 5:48 p.m. revealed resident #3 did not like nursing staff of the opposite gender to work with him/her.

Interview with social services staff B on 7/31/14 at 6:15 p.m. revealed the resident told him/her that he/she did not want nursing staff of the opposite gender for showers and the resident did not say why. Staff B confirmed he/she told the charge nurse.

Review of the facility policy, dated 2/11/14, for Resident's Rights revealed residents were

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 37 encouraged and allowed to make choices related to his/her service providers. The facility failed to honor resident #3's choice not to have caregivers of the opposite gender.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility census totaled 66 residents with 3 residents included in the sample. Based on observation, interview and record review, the facility failed to review/revise resident #3's care plan to include the resident's preference to have same gender care givers. (#3)	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175532	A. BUILDING _____ B. WING _____	C 08/14/2014

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F 280	Continued From page 38	F 280		

Findings included:

- Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnoses: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death).

Review of resident #3's profile page revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14.

Review of resident #3's significant change MDS (minimum data set) dated 7/18/14 revealed the resident had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder.

Review of resident #3's Cognitive Loss/Dementia CAA (care area assessment) dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired cognition. The resident usually understood others and was usually understood by others.

Review of resident #3's Urinary

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F 280	Continued From page 39	F 280		

Incontinence/Indwelling Foley Catheter CAA dated 8/1/14 revealed the resident had occasional urinary incontinence and his/her urinary frequency and incontinence had increased with a recent UTI (urinary tract infection) which the resident received antibiotics for. The resident required extensive assistance with toileting and personal hygiene and wore incontinent briefs for dignity.

Review of resident #3's temporary care plan dated 4/18/14 revealed the resident preferred only caregivers of the same gender as him/her, but when the resident readmitted to the facility on 5/30/14, that information was not included in his/her comprehensive care plan.

Review of resident #3's comprehensive care plan initiated on 2/26/14, revealed the toileting schedule portion of the care plan revealed the resident was continent of bowel and bladder and requested staff assistance with toileting. Staff revised the intervention on 2/26/14 to include for staff to assist the resident to the toilet for safety, monitor pericare, and provide assistance when needed. On 7/18/14, staff added an intervention alerting staff the resident was incontinent of bladder and continent of bowel and requested staff assistance for toileting for safety. It also directed staff to monitor pericare and provide assistance when needed and alerted staff the resident requested not to have caregivers of the opposite gender for personal cares. On 8/4/14, staff revised the intervention, but did not indicate what portion of the intervention was revised. Staff completed the care plan revision to include the resident did not want opposite gender caregivers on 7/18/14, though the previous temporary care plan had already identified the resident's

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F 280	Continued From page 40	F 280		

preference.

Review of a written statement from the former social services staff B dated 7/23/14 revealed several weeks prior, resident #3 had told him/her that he/she would prefer to receive showers from nursing staff of his/her same gender. The resident did not list anyone specific and did not complain about a staff member of the opposite gender. The resident was confused at times during the course of the conversation. The social worker let the charge nurse and administrator know of the resident's request to have a staff member of his/her same gender give him/her a shower.

Interview on 7/31/14 at 12:00 p.m. with resident #3's family member revealed the resident especially had a problem with nursing staff of the opposite gender. The resident had reported to the family member he/she had asked staff E not to come into his/her room and had told other staff he/she did not want staff E in his/her room.

Interview with licensed nursing staff J on 7/31/14 at 5:48 p.m. revealed resident #3 did not like nursing staff of the opposite gender to work with him/her.

Interview with social services staff B on 7/31/14 at 6:15 p.m. revealed resident #3 told him/her that he/she did not want nursing staff of the opposite gender for showers and the resident did not say why. Staff B reported he/she did not question it because there were many residents that did want nursing staff of the opposite gender to provide personal cares. Staff B confirmed he/she did not document the conversation with the resident anywhere, but told the charge nurse.

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F 280	Continued From page 41 Interview with administrative staff A on 7/31/14 at 1:27 p.m. revealed resident #3 stated he/she liked the staff of the same gender when interviewed. Staff A reported all of the night shift nursing staff of the opposite gender were non-Caucasian. Interview with administrative staff A on 8/5/14 at 4:24 p.m. revealed staff A reported all of the suspended non-Caucasian opposite gender staff were very consistent and knew resident #3 did not want staff of the opposite gender to care for him/her and had not wanted opposite gender caregivers since 7/3/14. Staff A reported the resident had not had any personal cares provided by a staff member of the opposite gender since 7/3/14 that he/she knew of. Review of the facility policy, dated 12/27/13, for Care Plan Revisions revealed staff were to update the resident's care plan with any changes in care or treatment approaches. The facility failed to update resident #3's comprehensive care plan to include the resident did not want caregivers of the opposite gender on 7/3/14 when the resident reported it to staff.	F 280		